

LASER PAIN CENTER

CONFIDENTIAL PATIENT CASE HISTORY

PATIENT INFORMATION

Today's Date _____ Social Security # _____ Date of Birth _____ Age _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Work Phone _____

Email _____ Sex Male Female

Marital Status **M S W D**

Height _____ ' _____ " Weight _____ lbs No. of Children _____ Ages _____

Occupation _____ Employer _____

Spouse Name _____ Spouse Occupation _____

Primary Care Physician _____ Phone _____

How were you referred to our office? _____ Have you had chiropractic care before? **Y/N**

If minor, name of parent of guardian _____

Who should we contact in case of emergency? _____

CURRENT COMPLAINTS

1. Please **circle** all that apply: **NECK / MID BACK / SHOULDERS / LOW BACK / ARMS / LEG / KNEE HEADACHES / NUMBNESS / WEAKNESS**
- Other Complaints: _____
2. How long have you had this condition? _____ Have you had this condition in the past? **Y/N**
3. Activities that are affected: **Work** **Sitting** **Caring for myself/family** **Walking** **Bending**
 Driving **Sleeping** **Computer Work** **Stairs** **Housework**
4. Rate your **Pain / Dysfunction**: (LEAST) **1 2 3 4 5 6 7 8 9 10** (MOST)
5. Is this condition progressively getting worse? **Yes / No / Same**
6. How long has it been since you've really felt good? _____
7. Other Doctors you have seen for this condition: _____
8. List treatment, procedures, surgeries for this condition: _____
9. Have you had any of the following for this condition: MRI / CT scan / XRays / Injections
10. Has any other treatment helped? If so, what treatment? _____
11. What medications are you taking? _____
12. Is this condition due to an accident? If so, what type? _____
13. Have you been involved in an automobile accident within the Last year Five years Never
14. Date of last physical examination: _____ Doctor's Name: _____

HEALTH HISTORY (Check if current or in the past)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> FAINTING/SEIZURES/EPILEPSY | <input type="checkbox"/> INSULIN |
| <input type="checkbox"/> FREQUENT NECK PAIN | <input type="checkbox"/> DIABETES | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> LOWER BACK PROBLEMS | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> DISC PROBLEMS NECK/LOW BACK | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> SHINGLES |
| <input type="checkbox"/> WHIPLASH | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> NUMBNESS/TINGLING ARMS/LEGS | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> NEUROPATHY |
| <input type="checkbox"/> HEART ATTACK OR STROKE | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> SINUS PROBLEMS | |
| <input type="checkbox"/> ALCOHOL/DRUG ABUSE | <input type="checkbox"/> DIFFICULTY BREATHING | |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> TUBERCULOSIS | |
| <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> VENERAL DISEASE | |
| <input type="checkbox"/> ARTIFICIAL VALVES | <input type="checkbox"/> ULCERS/COLINITIS | |
| <input type="checkbox"/> ARTIFICIAL BONES/JOINTS | <input type="checkbox"/> IRRITABLE BOWELS | |

FAMILY HISTORY

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIABETES | <input type="checkbox"/> SCOLIOSIS |
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> OTHER _____ | |

ALLERGIES: Please list:**LIST SURGERIES & YEAR PERFORMED:****SOCIAL HISTORY :** Do you smoke? Yes No In the Past Alcohol use? Yes No**WOMEN ONLY** Are you pregnant? Yes No Are you nursing? Yes No**IMPORTANT INFORMATION**

Have you ever been diagnosed with cancer? Y/N, explain: _____

Do you have an implanted neurostimulator device? Y/N, where: _____

Do you have a pacemaker? Y/N _____

Please check any of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Take medication that increases sensitivity to sunlight | <input type="checkbox"/> Take anticoagulants |
| <input type="checkbox"/> Have a seizure disorder that is triggered by light | <input type="checkbox"/> Are pregnant |
| <input type="checkbox"/> Have hemorrhagic diatheses | <input type="checkbox"/> Have HIV positive history |
| <input type="checkbox"/> Been injected with steroids in the past 2-3 weeks | <input type="checkbox"/> Have a pacemaker |
| <input type="checkbox"/> Have a cancerous lesion(s) or history of cancerous lesions | <input type="checkbox"/> Leukemia |

Patient or Legal Guardian Signature _____ **Date** _____

FINANCIAL POLICY

I understand that I am fully responsible for payment of all charges, including but not limited to, deductibles and copayments related to my care. I understand that Laser Pain Center requires full payment before any service be rendered and my balance should **not exceed \$200.00** at any given time; **Laser Pain Center** does not mail monthly statements to patients. If my balance is not paid in a monthly or timely fashion, I promise to pay any and all collections, court and attorney's fees in the collection of my account. I further understand that I will pay upon notice, to **Laser Pain Center** any balance due upon my account.

Patient or Authorized Signature X

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

AUTHORIZATION AND RELEASE: I authorize payment of benefits directly to **Laser Pain Center**. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

In addition, I have read and agree to the above **Assignments, Financial Policies, Notices, Releases and Consent forms and acknowledge Laser Pain Center does NOT accept or participate in any insurance plans and will not submit any bills or information to any insurance company.**

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Patient or Authorized Signature X

Date

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

I, _____ have read a copy of **Laser Pain Center's** notice of **Patient Privacy Practices**.

The patient understands and agrees to allow this chiropractic office to use their **Patient Health Information** for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the **privacy of your Patient Health Information**, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Patient or Authorized Signature X

Date

LASER PAIN CENTER

Patient Name _____ Date _____

PATIENT INFORMED CONSENT

Before you receive care as a patient of Laser Pain Center, it is important that you read this Consent and understand the nature of treatment. Laser Pain Center utilizes a multidisciplinary approach to health and wellness. Treatment usually involves a blend of laser therapy, acupuncture, herbal medicine, and manual medicine. To understand the risk associated with care, you need to understand these unique modalities.

Laser Therapy is a non-surgical application of laser light. Unlike most other forms of therapy, laser therapy is classified “actinotherapy” as it results in a chemical/metabolic change of the involved tissues. Thus, laser therapy can relieve pain, decrease inflammation, accelerate tissue healing (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of medical treatment, there are associate risks as well as benefits. Laser exposure to the eyes during the procedure may result in damage of the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms. To prevent adverse reactions to laser therapy, all patients must adhere to the guidelines for care supplied separately.

"Acupuncture" means a form of health care performed by the insertion and removal of specialized needles, with or without the use of supplemental techniques, to specific areas of the human body. *See* Ohio Statute 4762.

Manual medicine (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

“Chiropractic physicians” examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Ohio Statute 4734.01.

The undersigned Patient understands and acknowledges that there are risks associated with the application of laser chiropractic medicine, chiropractic care, acupuncture, therapy including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, pneumothorax, spinal injury, stroke, vision disturbances and others. The most common side effect following any treatment is an ache or stiffness at the site of the treatment.

I, hereby give authorization for **consent of treatment to Laser Pain Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with treatment at Laser Pain Center and application of therapeutic modalities such as Laser, heat, ice, ultrasound, traction, muscle stimulation, acupuncture, herbal medicine, chiropractic and others treatments by **Laser Pain Center. All my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X

Date

REVIEW OF SYSTEMS - LASER PAIN CENTER

Do you have: (please check all that apply):

Constitutional:

Fevers Weight loss Difficulty sleeping Tiredness or fatigue Chills Night sweats None

Eyes:

Flashing lights or "stars" Blind spots Double vision None

Ears, Nose, Throat, Mouth:

Earache or discharge Ringing in ears Difficulty hearing Nose bleeds Sinusitis Hoarseness
 Sores in mouth Sore throats None

Cardiovascular:

Chest pain Squeezing or tightness in chest Angina Need to sleep with head of the bed elevated
 Cramps in buttocks, thighs or calves when walking Shortness of breath at rest or walking/climbing
 Palpitations or fluttering heart Poor circulation Gangrene Swelling of hands, face, legs or feet
 High cholesterol None

Respiratory:

Cough Sputum production Coughing up blood Pleurisy Wheezing Asthma None

Gastrointestinal:

Nausea or vomiting Diarrhea Constipation Abdominal pain Vomiting of blood Very dark or light stool
 Jaundice Liver or gall bladder problems Colitis or other bowel problems Bleeding from rectum
 Ulcer None

Genitourinary:

Blood in urine or very dark urine Get up at night to urinate Burning with urination Unusual urgency to urinate
 Difficulty in getting urine stream started Kidney stones Prostate problems Bladder problems
 Albumin or protein in urine Pus in urine Infection in urine Large amounts of urine or very frequent urination None

Musculoskeletal:

Low back pain Neck pain Muscle ache Joint pain Mid back pain Shoulder/arm pain Hip/leg pain
 Arthritis None

Neurological:

Headaches Drooping of face Loss of strength in hands, arms, legs, feet Numbness/tingling
 Seizures Loss of consciousness Dizziness Fainting spells None

Skin:

Rashes Skin ulcers Nodules on skin None

Emotional/Psychiatric:

Depression Anxiety Psychiatric problems None

Endocrine:

Enlarged thyroid Sweating Diabetes Excess thirst Change in appetite Feeling unusually hot or cold
 Flushing Abnormal menses Post-menopausal None

Hematologic/Lymphatic/Oncologic:

Anemia Iron deficiency Enlarged lymph glands Easy bruising Cancer None

Allergic/Immunologic:

Hay fever Seasonal allergies Other _____ None

Patient Signature

Date

Physician Signature